PATIENTS CLINIC (SURESH NEKURI, MD & DANIELLE DAVIS, FNP)

PHONE# (423)353-1175 & FAX # (423)353-1177

1532 WEST ANDREW JOHNSON HWY

MORRISTOWN TN 37814

TODAYS DATE: _____

PATIENT INFORMATION

SOCIAL SECURITY NUMBER _____ SEX : MALE/FEMALE DOB: _____

LAST NAME_____FIRST NAME_____MIDDLE INITIAL_____

ADDRES:_____APT#_____

CITY:_____STATE_____ZIP_____

HOME PHONE: ( )_____CELL: ( )_____

EMAIL:_____

EMPLOYED: (YES) (NO) IF YES WHERE:_____

EMERGENCY CONTACT :
NAME:_____NUMBER_____

RESPONSIBLE PARTY INFORMATION (PERSON RESPONSIBLE FOR ACCOUNT

LAST NAME :_____FIRST:_____MIDDLE INIYIAL_____

ADDRESS:_____APT:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE: ( )_____CELL: ( )_____

RELATIONSHIP TO PATIENT :_____

EMPLOYER:_____

WORK PHONE: ( )_____

HOW DID YOU HEAR ABOUT US (PATIENTS CLINIC)???

_____

_____

PATIENTS CLINIC CONSENT TO RELEASE MEDICAL INFORMATION.

_____ GIVE MY PERMISSION FOR PATIENTS CLINIC TO SHARE MY MEDICAL INFORMATION WITH THE FOLLOWING INDIVIDUALS ,

NAME : _____

RELATIONSHIP TO PATIENT: _____

PHONE# _____

NAME: _____

RELATIONSHIP TO PATIENT _____

PHONE# _____

MAY WE CONTACT YOU AT WORK? _____ WORK # _____

DO YOU HAVE AN ADVANCED DIRECTIVES (LIVING WILL) YES/NO

IF YOU DO NOT PLEASE INQUIRE IF INTERESTED . THANK YOU .

WE REQUIRE 24 HOURS NOTICE IN THE EVENT OF AN APPOINTMENT CANCELLATION.

PLEASE REVIEW AND SIGN

1.) SELP PAY PATIENTS WILL BE RESPONSIBLE FOR PAYING AT TIME OF SERVICE, (NO EXCEPTIONS!!!!)

2.) IF YOU MISS YOUR APPOINMENT AND YOU RUN OUT OF MEDICINE , WE WILL NOT SCHEDULE YOU UNTIL WE HAVE A OPEN APPT.

3.) IF YOU HAVE A YEARLY DEDUCTIBLE YOU WILL BE RESPONSIBLE FOR PAYING THAT AT TIME OF SERVICE.THE REMAINING BALANCE WILL BE DUE AFTER THE INSURANCE PROCESSING IS COMPLETED.

4.) FMLA FORMS WILL BE $10.00 AND DISABILITIES FORMS WILL BE $20.00 FOR US TO COMPLETE .

5.) IF WE ESTABLISH A PATIENT PLAN WITH YOU AND ITS NOT KEPT, THE ACCT. WILL BE CONSIDERED FOR COLLECTIONS AND DISMISSAL AS A PATIENT .

6.) WE CANNOT CALL IN ANY MEDICATION INCLUDING ANTIBIOTICS UNTIL ONE OF OUR PROVIDERS HAVE SEEN YOU.

7.) THERE WILL BE A $30.00 FEE ON ALL CHECKS, IF WE RECEIVE A ONE WE WILL NO LONGER BE ABLE TO EXCEPT A CHECK FROM YOU AS A PAYMENT.

8.) I GIVE PERMISSION FOR THE STAFF TO LEAVE A MESSAGE ON MY HOME/CELL VOICEMAIL .

9.) I AGREE PATIENTS CLINIC WILL CALL TO REMIND ME OF MY UPCOMING APPOINTMENTS.

10.) IF YOU CALL IN NEEDING REFILLS WE WILL ONLY CALL THESE IN BETWEEN THE HOURS OF 12-1 AND AFTER 5PM., IT MAY TAKE UP TO 24 HOURS FOR US TO GET THESE TOO YOU.

11.) WE WILL NOT REVIEW LAB WORK OVER THE PHONE , YOU WILL HAVE TO COME INTO THE OFFICE AND REVIEW THESE WITH ONE OF OUR PROVIDERS.

I _____ AGREE TO PATIENTS CLINIC POLICIES AND PROCEDURES.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone: H) _____ Phone: W) _____

Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone: _____

Facility Address: _____ Facility Fax: _____

City, ST, Zip: _____

Dates and Types of Information to disclose:

☐ 2 years prior from last date seen

☐ Dates Other: _____

☐ Specific Information Requested: _____

The purpose of disclosure is:

☐ Change of Insurance or Physician

☐ Continuation of Care (e.g., VA Med Ctr)

☐ Referral

☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____ ☐ Please mail records.

☐ Please fax records.

Fax: _____ Phone: _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status.) Date

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

PATIENTS CLINIC

1532 WEST ANDREW JOHNSON HWY

MORRISTOWN TN 37814

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: YOU HAVE THE RIGHT, AS A PATIENT TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED SURGICAL, MEDICAL OR DIAGNOSTIC PROCEDURE TO BE USED SO THAT YOU MAY MAKE THE DECISION WHETHER OR NOT TO UNDERGO ANY SUGGESTED TREATMENT OR PROCEDURE AFTER KNOWING THE RISKS AND HAZARDS INVOLVED. AT THIS POINT IN YOUR CARE, NO SPECIFIC TREATMENT PLAN HAS BEEN RECOMMENDED. THIS CONSENT FORM IS SIMPLY AN EFFORT TO OBTAIN YOUR PERMISSION TO PERFORM THE EVALUATION NECESSARY TO IDENTIFY THE APPROPRIATE TREATMENT AND/OR PROCEDURE FOR ANY IDENTIFIED CONDITION (S).

THIS CONSENT PROVIDEDE US WITH YOUR PERMISSION TO PERFORM REASONABLE AND NECESSARY MEDICAL EXAMINATIONS, TESTING AND TREATMENT. BY SIGNING BELOW, YOU ARE INDICATING THAT (1) YOU INTEND THAT THIS CONSENT IS CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED, AND (2) YOU CONSENT TO TREATMENT AT THIS OFFICE OR ANY OTHER SATELLITE OFFICE UNDER COMMON OWNERSHIP. THE CONSENT WILL REMAIN FULLY EFFECTIVE UNTIL IT IS REVOKED IN WRITING - YOU HAVE THE RIGHT AT ANY TIME TO DISCONTINUE SERVICES.

YOU HAVE THE RIGHT TO DISCUSS TREATMENT PLAN WITH YOUR PHYSICIAN ABOUT THE PURPOSE, POTENTIAL RISKS AND BENEFITS OF ANY TEST ORDERED FOR YOU. IF YOU HAVE ANY CONCERNS REGARDING ANY TEST OR TREATMENT RECOMMENDED BY YOUR HEALTH CARE PROVIDER, WE ENCOURAGE YOU TO ASK QUESTIONS.

I VOLUNTARILY REQUEST A PHYSICIAN, AND/OR MID LEVEL PROVIDER (NURSE PRACTITIONER, PHYSICAL ASSISTANT, OR CLINICAL NURSE SPECIALIST) < AND OTHER HEALTH CARE PROVIDERS OR THE DESIGNEES AS DEEMED NECESSARY, TO PERFORM REASONABLE AND NECESSARY MEDICAL EXAMINATION, TESTING AND TREATMENT FOR THE CONDITION WHICH HAS BROUGHT ME TO SEEK CARE AT THIS PRACTICE. I UNDERSTAND THAT IF ADDITIONAL TESTING, INVASIVE OR INTERVENTIONAL PROCEDURES ARE RECOMMENDED, I WILL BE ASKEED TO READ AND SIGN ADDITIONAL CONSENT FORMS PRIOR TO THE TEST (S) OR PROCEDURE (S).

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENTS.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	DATE
PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE	RELATIONSHIP TO PATIENT
PRINTED NAME OF WITNESS	EMPLOYEE JOB TITLE
SIGNATURE OF PATIENT	DATE

Patients Clinic, Inc.

1532 West Andrew Johnson Highway; Morristown, TN 37814
Phone 423-353-1175 Fax 423-353-1177

Name_____ Date of birth____/____/____ Age _____ Sex_____
How did you hear about our practice?

Pharmacy name and number _____

Briefly state in the box below, the reason for your visit

Past Medical History			
Condition/Disease	Year Began	Condition/Disease	Year Began

Past Surgical Procedures/Hospitalizations/Serious Injuries or Fractures			
Operation/Hospitalization/Injury	Month/Year	Operation/Hospitalization/Injury	Month/Year

Other Physicians and Specialists List below, other physicians–GI, Urologist, Dermatologist, Psychiatrist, etc.

Medication or Food Allergies or Intolerances List below, any medication or food causing an allergic reaction			
Medication/Food	Reaction	Medication/Food	Reaction

Medications, Vitamins and Herbal Supplements					
Medication	Strength	Number of pills taken and frequency	Medication	Strength	Number of pills taken and frequency

Social, Educational, and Work History		
Work status (circle one): Employed Unemployed Retired Disabled	Current or Prior Occupation:	Hours worked per week:
Do you drink alcohol?	What type of alcohol?	Number of drinks per week?
Are you a former smoker?	If so, what year did you quit?	Number of years you smoked?
On average, how much do you smoke per day?		
Are you sexually active? Yes / No	Do you have sex with: men / women / both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to the HIV? Yes / No		

Family Health History				
Relative	Living or Deceased	Current age or Age at Death	Cause of Death	Health Problems
Father				
Mother				
Brother(s)				
Sister(s)				

Review of Symptoms

Please Review the Following Symptoms and Check Those Items That Are A Problem to You

Hepatitis C with hepatic coma	Agranulocytosis secondary to cancer chemotherapy	Alcoholism	Allergic Rhinitis	Allergy to Peanuts
Allergy to seafood	Anemia	Aneurysm of Unspecified Site	Anxiety	Arthritis
Asthma	Atherosclerosis	Atrial Fibrillation	Celiac Disease	Chest Pain
Chronic Kidney Disease	C O P D	Circulatory System Disorder	Colon Cancer	Congestive Heart Failure
Coronary Artery Aneurysm	Crohn's Disease	Cushing's Syndrome	Depression	Diabetes
Diabetes Mellitus	Emphysema	Gastroesophageal Reflux Disease	Gout	Headache
Hearing Loss	Heart attack	Heartburn	Hepatic Failure	Herniated Disc
High Blood Pressure	High Cholesterol	High Lipids	Hypertension	Hypothyroidism
Hyperthyroidism	Insomnia	Irritable Bowel Syndrome	Kidney Failure	Lung Cancer
Migraine	Mitral Valve Disorder	Mumps arthritis	Mumps Hepatitis	Obstructive Sleep Apnea
Osteoporosis	Stroke	Subclinical Iodine Deficiency	Sinusitis	Transitory neonatal

Disease Prevention and Health Maintenance

Please List Below the Most Recent Dates of Your Vaccines and Health Screening Tests

	Month/Year		Month/Year		Month/Year
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest Xray		HIV Test	